Dear Health Management Associates,

I have comments on the 1115 Waiver, as it has been implemented so far via the SMART Act and other legislation. My comments cover four areas: 1. Perverse incentives for perverse behavior on the part of private managed-Medicaid providers. 2. "'Coordination entities'" versus actual care coordination. 3. The absence of mental health services. 4. Perverse incentives to push patients out of their homes and into nursing homes.

Example of #1: A pediatric patient is in the County Hospital, taking an expensive medication for an expensive condition. The patient's mother had been successful bribed to put her child to enroll her child into a managed Medicaid entity in exchange for a Target gift card. When the child is ready to leave the County Hospital, the managed Medicaid entity suddenly becomes confused, sluggish, and uncoordinated about what Home Care Services that have available. Of course they promise them in their website, but the actual capacity to let the child go home is missing. And it just turns out, that every day the child is in the Hospital unnecessarily, the County system loses money (because the per diem reimbursement the County receives is far less than the cost of the medication) and the managed Medicaid entity saves money. It doesn't make any sense medically, but it sure makes sense for the managed-care entity financially. The State is sympathetic and tries to help "problem-solve" but it doesn't do what would really make a difference, which is to fine the managed-care entity for every day that they delay discharge.

2. The State-mandated "coordination entities" IlliniCare and Aetna Better Health are so far a complete bust in terms of actually coordinating care. They do, however, have well-developed systems for restricting care. There doesn't seem to be anyone at the State level who can intervene when the "care coordinators" at these entities refuse to do their jobs. I end up begging them to help me.

3. A patient is in desperate need for psychotherapy for depression. Because of her many health care conditions, she cannot take psychotropic medication. Even though she has both Medicaid and Medicare, you cannot find any reasonably experienced clinician to help her who will take her insurances. We end up applying for and receiving a grant from a private foundation, which is willing to pay for an experienced LCSW Social Worker to help her. The treatment is progressing well.

It is outrageous that the State Medicaid system won't reimburse LCSWs.

4. A patient with many complicated medical conditions is living on SS disability, with assistance from the Department of Rehabilitation Services (DORs) and a Section 8 Housing voucher. The DORs caseworker and the local housing authority representative get together and decide that the patient should be in a nursing home, against the wishes of the patient, the recommendations of the patient's doctors and a court order. Nevertheless, the DORs office and local housing authority continue to "suggest" the patient just go to a nursing home. It

would cost the State much more to keep the patient in a skilled nursing facility, but it would get the patient off the budget of DORs and the housing authority Section 8 system. As in the first example, DORs supervisors in Springfield cluck sympathetically, but they won't sanction the local DORs office in any meaningful way.

In conclusion, the actual reality of what the State is doing doesn't match the rhetoric in the concept paper for "The Path to Transformation." The State so far has lacked the will to actually try to save money through better care, and has settled for simply saving money.

Sincerely,

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